

## Complete Summary

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### GUIDELINE TITLE

VHA/DoD clinical practice guideline for the management of medically unexplained symptoms: chronic pain and fatigue.

### BIBLIOGRAPHIC SOURCE(S)

Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue Working Group. VHA/DoD clinical practice guideline for the management of medically unexplained symptoms: chronic pain and fatigue. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Jul. Various p. [148 references]

## COMPLETE SUMMARY CONTENT

SCOPE  
 METHODOLOGY - including Rating Scheme and Cost Analysis  
 RECOMMENDATIONS  
 EVIDENCE SUPPORTING THE RECOMMENDATIONS  
 BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS  
 QUALIFYING STATEMENTS  
 IMPLEMENTATION OF THE GUIDELINE  
 INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT  
 CATEGORIES  
 IDENTIFYING INFORMATION AND AVAILABILITY

## SCOPE

### DISEASE/CONDITION(S)

Medically unexplained symptoms (MUS): chronic pain and fatigue (also referred to as chronic fatigue syndrome or fibromyalgia)

### GUIDELINE CATEGORY

Diagnosis  
 Evaluation  
 Management  
 Treatment

### CLINICAL SPECIALTY

Family Practice  
 Infectious Diseases  
 Internal Medicine

Preventive Medicine  
Psychiatry  
Rheumatology

## INTENDED USERS

Advanced Practice Nurses  
Health Care Providers  
Physician Assistants  
Physicians

## GUIDELINE OBJECTIVE(S)

- To assist clinicians in primary care settings in all aspects of patient care related to medically unexplained symptoms: chronic pain and fatigue
- To promote efficient and effective assessment of patient's complaints
- To identify the critical decision points in management of patients with medically unexplained symptoms: chronic pain and fatigue
- To accommodate local policies or procedures, such as those regarding referrals to, or consultation with specialists
- To improve local management of patients with chronic unexplained illness and thereby improve patient outcomes

## TARGET POPULATION

Military personnel and veterans with medically unexplained symptoms

## INTERVENTIONS AND PRACTICES CONSIDERED

### Screening/Assessment

1. Clarification of symptoms (duration, onset, location, co-morbidity, previous episodes, intensity and impact, previous treatment and medications, past medical, surgical, and psychological history, and patient perception of symptoms)
2. Mental status examination (MSE) – Mini-Mental State Examination (MMSE)
3. Psychosocial assessment – Patient Health Questionnaire (PHQ)
4. Assessment of cognitive difficulties – forgetfulness, memory disturbance, problems with concentration
5. Assessment of sleep disturbance
6. Assessment of associated somatic symptoms
7. Assessment of unstable or urgent conditions, such as suicidal ideation, joint swelling, fever, significant weight loss, focal neurologic findings, severe anemia or elevated white blood cells
8. Assessment of pain
  - Standard pain drawing
  - Tender point evaluation – count, myalgic score, Manual Tender Point Survey (MTPS)
9. Assessment of patient perception – BATHE technique
10. Building therapeutic alliance
11. Medical record review

12. Diagnostic tests (complete blood count, electrolytes, blood urea nitrogen, creatinine, glucose, calcium, phosphate, liver function tests, total protein, thyroid-stimulating hormone, erythrocyte sedimentation rate, urinalysis)
13. Optional tests (Epstein-Barr virus, Lyme disease, immunologic function testing, neuroimaging)
14. General physical examination

## Diagnosis

1. Differential diagnosis, including mood, anxiety, and substance use disorders, myopathy, polymyositis, myasthenia gravis, multiple sclerosis, major depression, sleep apnea, narcolepsy, airflow limitation, cardiac failure, anemia, systemic lupus erythematosus, and influenza
2. Diagnosis documentation – anxiety, sleep apnea, upper airway resistance syndrome, fibromyalgia, chronic fatigue syndrome, or chronic multisymptom illnesses
3. Condition summary – problem list

## Management/Treatment

### Treatment Plan Development

1. Development of treatment options
2. Patient and family education
3. Patient collaboration
4. Patient consent
5. Patient self-management – exercise, diet, sleep hygiene, stress reduction, relaxation training, leisure activity schedule, pacing
6. Use of consultants – physical therapy, nutrition, social work, psychology, rheumatology
7. Social network – employer, spouse, friends

### Therapies for Fibromyalgia

#### Some Benefit

1. Graded aerobic exercise
2. Cognitive behavioral therapy (CBT)
3. Tricyclic antidepressants (TCAs) such as amitriptyline and cyclobenzaprine
4. Tramadol
5. S-adenosyl-L-methionine (SAME)
6. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine and venlafaxine
7. Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen
8. Sleep education (sleep hygiene)
9. Other antidepressants (non-SSRI, non-TCA)

#### Possible Benefit

10. Acupuncture
11. Biofeedback

12. Trigger point injection
13. Stretching
14. Massage therapy
15. Relaxation therapy
16. Myofascial release
17. Spinal manipulation
18. Hypnotherapy
19. Magnesium

#### Possibly Harmful

20. Xanax
21. Antivirals such as acyclovir
22. Antifungals
23. Antibiotics
24. Bed rest

#### Therapies for Chronic Fatigue Syndrome

##### Maximum Benefit

1. Cognitive behavioral therapy
2. Graded aerobic exercise

##### Some Benefit

3. Monoamine oxidase inhibitors (MAOIs), such as moclobemide and phenelzine
4. Nicotinamide adenine dinucleotide (NADH)
5. Sleep education (hygiene)
6. SSRIs such as fluoxetine (Prozac) and venlafaxine (Effexor)
7. Other anti-depressants (non-SSRI, non-TCA)

##### Possible Benefit

8. Relaxation
9. Flexibility exercise
10. Essential fatty acids
11. Magnesium
12. Low-dose, short term corticosteroid

#### Possibly Harmful

13. Fludrocortisone (Florinef), alone
14. Bed rest
15. Corticosteroid (hydrocortisone) – high dose or replacement
16. Antivirals such as acyclovir or amantadine
17. Antifungal
18. Immune therapy such as immunoglobulin, intravenous immunoglobulin (IVIG), dialyzable leukocyte extract (DLE), alpha interferon, and Poly (I)·Poly (C<sub>12</sub>U) (Ampligen)

## MAJOR OUTCOMES CONSIDERED

- Symptom control
- Prevention of complications and morbidities
- Adverse effects of therapeutic interventions

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)  
Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

1. Four experts (members of the Working Group) each developed a summary of key practice issues, based on evidence, for the management of chronic fatigue syndrome (CFS) and fibromyalgia (FM). The four drafts were then consolidated into one suggested summary of evidence by an editor.
2. Researchable questions were developed, based on the summary. The questions specified:
  - Population - characteristics of the target population
  - Intervention - diagnostic, screening, therapy, and assessment
  - Control - the type of control used for comparison
  - Outcome - the outcome measure for this intervention (morbidity, mortality, patient satisfaction, and cost)
3. A systematic and reproducible search of the literature was conducted. It focused on the best available evidence to address each key question, and ensured maximum coverage of studies at the top of the hierarchy of study types: evidence-based guidelines, meta analyses, and systematic reviews (Cochrane, EBM, EPC reports). These sources may yield a definitive answer to some questions.

The search continued using well-known and widely available databases that were appropriate for the clinical subject. Limits on language (English), time (1997 through June 2000) and type of research (Randomized Controlled Trials [RCT]) were applied. The search included Medline and additional specialty databases, depending on the topic.

The search strategy did not cast a wide net. Once definitive clinical studies that provided valid relevant answers to the question were identified, the search stopped. It was extended to studies/reports of lower quality (observational studies) only if there were no high quality studies.

4. Additional exclusion criteria were later applied. Typical exclusions were studies with physiological endpoints, or studies of populations that were not comparable to the population of interest (e.g., studies dealing with children and adolescents were excluded).
5. The assembled experts suggested numerous additional references. Copies of specific articles were provided to participants on an as-needed basis. This

document includes references through June 2000. During the final editing stages, important review documents were incorporated into the document and added to the reference list.

#### NUMBER OF SOURCE DOCUMENTS

Not stated

#### METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

#### RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence

I Evidence is obtained from at least one properly randomized controlled trial (RCT).

II-1 Evidence is obtained from well-designed controlled trials without randomization.

II-2 Evidence is obtained from well-designed cohort or case-controlled analytical studies, preferably from more than one center or research group.

II-3 Evidence is obtained from multiple time series, with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.

III Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

#### METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses  
Systematic Review with Evidence Tables

#### DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The results of the literature search were organized and reported in tables using a reference manager and spreadsheet software. The reports included the research question, the source, study type, measures, and conclusions.

The clinical experts evaluated the studies according to criteria proposed for judging the internal validity of randomized controlled trials (Agency for Health Care Policy and Research, 1996) and developed evidence tables.

The evidence tables, generated by the systematic process, were then compared to the summary developed in Step 1 of the evidence collection process. The summary was modified to reflect the evidence. The evidence tables and the summary guided the development of the algorithm and annotation for this guideline.

Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research. The Working Group reviewed the articles for relevance and graded the evidence using the rating scheme published in the U. S. Preventive Service Task Force Guide to Clinical Preventive Services, Second Edition (1996). The experts themselves, after an orientation and tutorial on the evidence grading process, formulated Quality of Evidence (QE) ratings. Each reference was appraised for scientific merit, clinical relevance, and applicability to the populations served by the Federal health care system. The QE rating is based on experimental design and overall quality. Randomized controlled trials received the highest ratings (QE=I), while other well-designed studies received a lower score (QE=II-1, II-2, or II-3). Quality, consistency, reproducibility, and relevance of the studies are also considered.

The recommendation rating (R) was formulated, using a rating scale from A to E. The specific language used to formulate each recommendation conveys the Working Group's opinion of both the clinical importance attributed to the topic and the available strength of evidence. When appropriate and necessary, expert opinion was formally derived from the Working Group to supplement or balance the conclusions reached from the scientific evidence review. Thus, the rating of R combines the significance of the scientific evidence and the considerations of standards of care and potential harm.

## METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

## DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

This guideline for the management of medically unexplained symptoms of chronic pain and fatigue is the product of many months of diligent effort and consensus building among knowledgeable individuals from the Veterans Health Administration, Department of Defense and academia, and guideline facilitators from the private sector.

The process of developing this guideline was evidence-based whenever possible. Evidence-based practice integrates clinical expertise with the best available clinical evidence derived from systematic research. Where evidence is ambiguous or conflicting, or where scientific data are lacking, the clinical experience of the multidisciplinary Working Group was used to guide the development of consensus-based recommendations.

## RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendation Rating

- A. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated.
- B. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered useful/effective.
- C. A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds.
- D. A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered not useful/effective.
- E. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration.

## COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

## METHOD OF GUIDELINE VALIDATION

Clinical Validation-Trial Implementation Period  
Peer Review

## DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The method of guideline review is broadly described in "Guidelines for Guidelines" on the [Veterans Health Administration \(VHA\) Web site](#) and applicable to all guidelines developed by Veterans Affairs/Department of Defense (VA/DoD). Briefly, a final draft of the guideline is distributed for field testing, comment and independent review. Network designated staff are asked to use the guideline in the direct care setting and provide feedback to key personnel and/or directly to the guideline development experts via the web page available for online comment. This portion of the field test is intended to provide feedback regarding the format and usability of the guideline and the companion implementation tools/guideline summary and pocket cards. Peer review of the guideline is completed by at least three VA/DoD staff, including primary care clinicians, who have been trained and previously assigned to perform the independent review.

After final editing to incorporate feedback as appropriate, the guideline, tools, and comments are submitted to the National Clinical Practice Guideline Council for review. This Council's recommendations and a summary of the guideline and the provider tools are forwarded to the Under Secretary for Health for signature and distribution.

## RECOMMENDATIONS

### MAJOR RECOMMENDATIONS

The major recommendations for the management of medically unexplained symptoms: chronic pain and fatigue in the primary care setting are summarized in

the "Key Points" which immediately follow. The complete recommendations are organized into 1 major algorithm. The algorithm, and the objectives and annotations that accompany it, are excerpted following the "Key Points." The quality of evidence grades (I, II-1, II-2, II-3, and III) and strength of recommendation grades (A-E) are defined at the end of the "Major Recommendations" field.

## Key Points

1. Establish that the patient has medically unexplained symptoms (MUS).
2. Obtain a thorough medical history, physical examination, and medical record review.
3. Minimize low yield diagnostic testing.
4. Identify treatable cause (conditions) for the patient's symptoms.
5. Determine if the patient can be classified as Chronic Multi-Symptom Illness (CMI) (i.e., has two or more symptoms clusters: pain, fatigue, cognitive dysfunction, or sleep disturbance).
6. Negotiate treatment options and establish collaboration with the patient.
7. Provide appropriate patient and family education.
8. Maximize the use of non-pharmacologic therapies:
  - Graded aerobic exercise with close monitoring
  - Cognitive behavioral therapy (CBT)
9. Empower patients to take an active role in their recovery.

## Medically Unexplained Symptoms: Chronic Pain and Fatigue Algorithm

### A. Patient with Medically Unexplained Symptoms (MUS)

#### Objective

Identify patients with persistent symptoms not explained by a known medical etiology.

#### Annotation

Patients managed by this guideline have symptoms that remain relatively unexplained after an appropriate medical assessment that includes focused diagnostic testing (Kroenke, Arrington, & Mangelsdorf, 1990; Kroenke & Price, 1993; Kroenke & Mangelsdorf, 1989). Patients are often given multiple labels that lack a well-defined disease explanation. Usual clinical features include a relative lack of objective signs and a chronic symptom course often marked by exacerbations, remissions, and recurrences. Therefore, clinical management must be based largely upon patient report, rather than specific findings on clinical examination or diagnostic testing (Engel & Katon, 1999a). A compassionate approach to patients with medically unexplained symptoms (MUS) is essential (Engel & Katon, 1999b).

### B. Obtain Additional History, Physical Examination, Mental Status Examination (MSE), and Psychosocial Assessment

#### Objective

Obtain comprehensive patient data to rule out alternative explanations for unexplained symptoms.

#### Annotation

A thorough and early review of all sources of information can help in validating the patient's health concerns, while communicating care and understanding--the necessary building blocks to an effective patient-clinician partnership. Sources of information include the following:

1. All medical records
2. Medical history and psychosocial assessment
3. Review of systems
4. Physical examination and mental status examination (MSE)
5. Routine test results
6. Standard health assessments

#### Additional Medical History

In obtaining a medical history, the clinician should focus on key symptoms that may suggest a well-defined disease explanation.

#### Physical Examination

Patients with unexplained symptoms have often been examined several times in the past. However, important details may have been overlooked due to time constraints or the frequency that clinicians encounter such complaints in the absence of objective findings. Setting aside time for a detailed and thorough examination is critical for the assessment and may also help in building an alliance with the patient, who in many cases was seen by several clinicians.

#### Mental Status Examination (MSE)

A careful MSE should be performed, including assessment of appearance, behavior, mood and affect, cognition, thought content and processes, and insight and judgment. A useful screen for cognitive impairment in elderly patients consists of four questions from the Mini-Mental State Examination (MMSE) (Koenig, 1996) (i.e., orientation to time, orientation to place, memorizing and repeating three non-related items, and spelling "world" backwards).

#### Psychosocial Assessment

A psychosocial assessment is critical in evaluating the patient with unexplained symptoms and should include a screening for suicidal ideation and substance use disorders.

The Patient Health Questionnaire (PHQ) is an excellent screening tool for assessing the presence of the most common psychiatric conditions associated

with complaints of fatigue: depression, symptoms, and anxiety (Spitzer et al., 1999; Spitzer et al., 1994).

C. Are Unstable or Urgent Condition(s) Present?

Objective

Identify patients that are unstable and need immediate treatment.

Annotation

Unstable or urgent conditions represent situations that mandate immediate attention. A complete discussion of diagnosis and management of the entire range of possible urgent conditions is beyond the scope of this guideline. These conditions are generally recognized and managed by the astute primary care clinician.

Some potentially unstable or urgent conditions include (but are not limited to) the following:

1. Suicidal ideation or psychosis
2. Objective evidence of joint swelling
3. Fever (over 101.1 degrees F/38.4 degrees C)
4. Significant weight loss
5. Focal findings on neurological examination
6. Severe anemia or elevated white blood cells

D. Clarify the Symptoms; Build Therapeutic Alliance; Schedule Additional Appointments of Longer Duration

Objective

Obtain detailed information on the patient's symptoms and health concerns, allowing adequate time to enhance the patient's trust and faith in the clinician.

Annotation

Clarify The Symptoms

Patients who present with unexplained pain or fatigue often carry a cluster of symptoms that must be understood as accurately as possible. Taking an accurate history is an essential part of the diagnostic work-up.

See Table 1, "Clarification of Symptoms" in the original guideline document.

Build Therapeutic Alliance

The lack of diagnosis or effective treatment can make the management of patients with unexplained symptoms challenging. It may also cause frustration for both the patient and the provider. A high level of patient trust and faith in the clinician is required in order to maintain continuity of care and

continue patient management through regular follow-up appointments. The initial evaluation helps establish a special partnership between the patient and clinician. To strengthen the partnership with the patient, the clinician should (Stuart & Lieberman, 1993):

- Acknowledge and indicate commitment to understand the patient's concerns and symptoms.
- Encourage an open and honest transfer of information that will provide a more comprehensive picture of the patient's concerns and medical history.
- Indicate commitment to allocate sufficient time and resources to resolving the patient's concerns.
- Avoid open skepticism or disapproving comments in discussing the patient's concerns.

At each patient visit, the clinician should consider the following:

- Ask if there are unaddressed or unresolved concerns.
- Summarize and explain all test results.
- Schedule follow-up visits in a timely manner.
- Explain that outstanding or interim test results and consultations will be reviewed during the follow-up visits.
- Offer to include the concerned family member or significant other in the follow-up visit.

#### Schedule Additional Appointments of Longer Duration

The clinician's initial evaluation helps establish a high level of trust by demonstrating that the patient's symptoms will be taken seriously. Continuity of care is also essential for building a trusting therapeutic alliance and rapport. Continuity is achieved through regularly scheduled follow-up appointments that encompass:

- Several appointments
- Extended visits
- Setting aside time to review the medical record and laboratory results

#### E. Revisit the Medical Record

##### Objective

Clarify the history of the MUS.

##### Annotation

Review the patient's medical record for co-morbidities, prior episodes, occurrences of other unexplained symptoms, prior evaluations, and the nature and extent of prior therapy.

The review should include the following:

- Complete medical history

- Family and social history
- Occupational and deployment history
- Exposure to possible risks, hazards, and toxic agents
- Prescription history, including over-the-counter medications and herbs
- Clinical notes
- Other documented history and physical examinations
- Radiological, laboratory, and other ancillary test results
- Effectiveness of previous therapies and reasons for past treatment failures or successes

F. Obtain Focused Diagnostic Tests, If Not Already Done

Objective

Identify objective findings that may suggest the diagnosis.

Annotation

After a complete history and physical examination, there are several Australia routine laboratory tests that will assist in completing the patient assessment (Chronic Fatigue Syndrome Guideline, 1997):

- Complete blood count
- Electrolytes
- Blood urea nitrogen
- Creatinine
- Glucose
- Calcium
- Phosphate
- Liver function tests
- Total protein
- Thyroid-stimulating hormone
- Erythrocyte sedimentation rate
- Urinalysis

The clinician also should ensure that health care maintenance is up to date.

The following tests should only be ordered if the history or physical examination results strongly suggest the need (Centers for Disease Control (CDC), 1999):

- Serological tests for:
  - Epstein-Barr virus
  - Lyme disease (in the absence of polyarthritis, history of tick bite, or erythema chronicum migrans)
  - Immunologic function testing
- Neuroimaging

G. Can Another Condition or Disease (Including Mood, Anxiety, and Substance Use Disorders) Explain (or Cause) the Symptoms?

Objective

Identify patients for whom treatment of cause may resolve the symptoms.

#### Annotation

After obtaining a detailed history, completing a thorough physical examination, obtaining laboratory test results, and using a screening tool the clinician should determine whether an explanatory or causal condition can be diagnosed or whether the symptoms remain medically unexplained.

See Table 2, "Patient's Description of Fatigue" in the original guideline document for examples of related diagnoses. In most instances, the symptoms of chronic fatigue syndrome (CFS) can be distinguished from the closely related phenomenon of somnolence, muscle weakness, neuromuscular fatigability, depressed mood, or anhedonia.

When considering depression, the clinician should assess whether the symptoms are causing the depression or the depression is resulting in physical complaints. Physical illness may cause psychosocial distress through a direct biological link, such as through neurotransmitters involved in both pain and mental disorders. Physical symptoms may cause emotional distress by overwhelming an individual's ability to cope. Distress may increase unhealthy behaviors that increase the risk of such symptoms. The disordered sleep and changes in autonomic nervous system functioning associated with stress may cause these symptoms. Finally, both mental disorders and MUS may be found together in some people, simply by chance.

### H. Consider Initiating Symptom-Based Treatment Modalities

#### Objective

Reduce symptoms and promote functioning and well-being.

#### Annotation

Although the criteria for CFS require six months duration of symptoms prior to making the diagnosis, the initiation of appropriate treatments for unexplained symptoms and for myalgias may be considered earlier.

There is a point in the course of the diagnostic work-up and clinical monitoring at which the symptoms may appear to be "unexplained." The time that elapses in reaching this point varies.

- Early interventions should include restoration of sleep and management of pain.
- The clinician must maintain an ongoing vigilance to the possibility of emerging diagnosable conditions.

#### Recommendation

Early intervention may improve prognosis. (B)

- I. Does Patient Present With 2 or More of the Following: Fatigue, Pain, Sleep Disturbance, or Cognitive Dysfunction?

Objective

Identify and describe signs and symptoms for classification of chronic fatigue syndrome/fibromyalgia (CFS/FM).

Annotation

Chronic unexplained symptoms are very common in the general population. In many instances, these symptoms occur in isolation (e.g., fatigue and headaches). However, it is also common for these symptoms to aggregate in individuals, leading to hypothesized "syndromes" that have been given a variety of terms, such as CFS, FM, and somatoform disorders. There are substantial data suggesting that overlapping illnesses have common mechanisms and respond to similar types of interventions. Careful assessment of fatigue, pain, cognitive difficulties, sleep disturbance, and associated physical symptoms, considering their impact on the patient in isolation and aggregate, will allow the clinician to reach an appropriate diagnosis. See the original guideline document for a fuller discussion of these symptoms and their assessment.

- J. Document the Diagnosis: Consider Anxiety, Sleep Apnea, Upper Airway Resistance Syndrome, Fibromyalgia (FM), Chronic Fatigue Syndrome (CFS), or Chronic Multisymptom Illnesses (CMI)

Objective

Assign specific diagnostic labels that may have implications in the clinical course of treatment for patients with MUS.

Annotation

Chronic Fatigue Syndrome

CFS is the current term used to describe a syndrome involving a set of defined (yet in many ways, non-specific) symptoms and behaviors that include, as a defining element, severe disabling fatigue and a combination of associated symptoms including cognitive impairments (memory and concentration), sleep disturbances and musculoskeletal pain. The condition has been described for centuries using a variety of nomenclatures (e.g., febricula, nervous exhaustion, neurasthenia, epidemic neuromyasthenia, benign myalgic encephalomyelitis, royal free disease, and chronic mononucleosis) (Shafran, 1991; Demitrack, 1998). To date, no clear pathophysiology or etiologies have been established, and current evidence points to a heterogeneous and multi-causal pathogenesis (Wilson et al., 1994; Schwartz, 1988; Demitrack & Greden, 1991; Demitrack, 1997). In 1994, an international study group coordinated by the Centers for Disease Control (CDC) established the most widely accepted criteria for case definition of CFS (Fukuda et al., 1994).

A case of chronic fatigue syndrome is defined by the presence of:

Clinically evaluated, unexplained, persistent or relapsing fatigue that is of new or definite onset; is not the result of ongoing exertion; is not alleviated by rest; and results in substantial reduction in previous levels of occupational, educational, social, or personal activities.

and

Four or more of the following symptoms that persist or reoccur during six or more consecutive months of illness and do not predate the fatigue:

- Self-reported impairment in short term memory or concentration
- Sore throat
- Tender cervical or axillary nodes
- Muscle pain
- Multi-joint pain without redness or swelling
- Headaches of a new pattern or severity
- Unrefreshed sleep
- Post-exertional malaise lasting >24 hours

#### Fibromyalgia

FM is the current term used to describe a syndrome involving a set of defined (yet in many ways, non-specific) symptoms and behaviors that include, as a defining element, widespread musculoskeletal pain and tenderness. The condition has been described for centuries using a variety of nomenclatures (e.g., muscular rheumatism, fibrositis, fibromyositis, and psychogenic rheumatism). To date, no clear pathophysiology or etiologies have been established. In 1990, a committee of the American College of Rheumatology (ACR) established the most widely accepted criteria for case definition of FM (Wolfe, Smythe & Yunus, 1990). The American College of Rheumatology criteria include the following:

8. History of widespread pain of at least 3 months duration.

Definition. Pain is considered widespread when all of the following are present: pain in the left side of the body, pain in the right side of the body, pain above the waist, and pain below the waist. In addition, axial skeletal pain (cervical spine or anterior chest or thoracic spine or low back) must be present. In this definition, shoulder and buttock pain is considered as pain for each involved side. "Low back" pain is considered lower segment pain.

9. Pain in 11 of 18 tender point sites on digital palpation (performed with an approximate force of 9 lb/4 kg).

Definition. Pain, on digital palpation, must be present in at least 11 of the following 18 sites:

- Occiput: bilateral, at the suboccipital muscle insertions.

- Low cervical: bilateral, at the anterior aspects of the intertransverse spaces at C5-C7.
- Trapezius: bilateral, at the midpoint of the upper border.
- Supraspinatus: bilateral, at origins above the scapula spine near the medial border.
- Second rib: bilateral, at the second costochondral junctions, just lateral to the junctions on upper surfaces.
- Lateral epicondyle: bilateral, 2 cm distal to the epicondyles.
- Gluteal: bilateral, in upper outer quadrants of buttocks in anterior fold of muscle.
- Greater trochanter: bilateral, posterior to the trochanteric prominence.
- Knee: bilateral, at the medial fat pad proximal to the joint line.

For a tender point to be considered "positive" the subject must state that the palpation was painful. "Tender is not to be considered 'painful'."

The presence of a second clinical disorder does not exclude the diagnosis of fibromyalgia.

Concurrent symptomatology is nearly universal and includes fatigue, headaches (both migraine and musculoskeletal), paresthesias, hearing/ocular/vestibular complaints, cognitive difficulties (memory and concentration), "allergic" and chemical sensitivity symptoms, non-cardiac chest pain, palpitations, dyspepsia, irritable bowel syndrome and affective/somatoform disorders (Clauw, 1995).

### Labeling

There is insufficient evidence to allow clinicians to predict the impact that diagnostic labels such as FM syndrome, CFS, multi-chemical sensitivity (MCS), CMI, or Gulf War Illness (GWI) will have on the clinical course of patients with these symptoms. There is evidence, however, to suggest that the clinician should consider the following potential impacts:

- Assigning specific diagnostic labels may have implications in the clinical course for a particular individual with MUS.
- There may also be negative effects of labeling. A diagnostic label may sometimes unnecessarily cause a patient to define him or herself as ill, an effect that could be especially problematic in occupational health care settings.
- The potential risks and benefits of applying a particular diagnostic label to unexplained symptom clusters should be weighed by the clinician and discussed with the patient prior to applying such a diagnostic label.
- The clinician should consider generic approaches to managing MUS; such approaches may be useful, without having to rely on specific diagnostic labels.

## K. Summarize the Patient's Condition; Develop a Treatment Plan

### Objective

Identify the patient's problems and potential treatment options.

#### Annotation

Assure that the patient understands the meaning and impact of CFS/FM syndrome on their life and the potential improvement a recommended treatment may offer. A final acceptable treatment plan should be negotiated with the patient and documented in the medical record.

- Prepare a summary of the problems and potential treatment plans prior to meeting the patient.
  - Develop a problem list with an assessment of problem severity and urgency for treatment.
  - Develop treatment options for discussion with the patient.
- Educate the patient.
  - Discuss the general concept of MUS and how problems associated with this diagnosis apply to the patient.
  - Evaluate the patient's understanding.
  - Describe treatment options and the associated risks and benefits.
  - Describe the prognosis of the illness.
- Collaborate with the patient and determine the patient's preferences.
  - Determine the patient's goals for recovery.
  - Explore and discuss the patient's beliefs regarding his or her illness.
  - Determine if the patient agrees with the priority and severity of the problems and urgency for treatment.
  - Determine the level of the patient's agreement with the recommended treatment or one of the alternative options.
  - Determine the patient's motivation to begin treatment and identify barriers to treatment.
  - Obtain the patient's consent to the treatment plan.
- Empower the patient for self-management.
  - Move the responsibility of patient improvement from the treatment team to the patient.
  - Encourage a change in life-style, including exercise, diet, sleep hygiene, stress reduction, relaxation training, leisure activity schedule, and pacing.
- Implement the treatment plan.
  - Coordinate treatment plan activities.
  - Establish a referral and interdisciplinary team approach, if indicated.
- Follow-up.
  - Monitor treatment progress and patient improvement.
  - Establish a regular follow-up schedule throughout and after treatment.

#### Role of the Primary Care Manager (PCM)

In the course of the assessment, the primary care provider should also serve as the primary care manager (PCM) and develop a problem list that summarizes the findings of specialty consultations and diagnostic procedures

related to the diagnosis of CFS/FM or CMI. The PCM should determine the severity of each identified problem and the impact it will have on the patient's functional ability and quality of life, so that a baseline can be established against which improvements can be assessed. The PCM should also identify problems for which treatment is most urgently recommended. The most urgent treatments may be defined as those treatments expected to result in the greatest improvement when addressing the most severe problems.

### Role of Consultants

The PCM is not expected to directly provide treatment, but is expected to serve as the focal point for a multidisciplinary approach to treatment that may span the continuum of care, beginning with self-management. The treatment team may include those from whom prior consults have been obtained, such as physical therapy, nutrition, social work, psychology, rheumatology, and significant others within the patient's social network. The PCM, with patient consent, may find it useful to involve the patient's employer/supervisor, spouse, and friends in the defined treatment team.

Mental health professionals should provide input into implementing psychotherapies and psychopharmacology in outpatient or partial hospitalization settings. Social workers should help build family and social support networks, or recommend changes in the patient's living situation, in order to create a positive support network. Within the most intensive treatment setting within the continuum of care, residential treatment may be required to assure the presence of a support network.

### Continuum of Care

A continuum of care should cover a range of levels of intensity, including self-care in the home through outpatient treatment, partial hospitalization, residential treatment, and hospitalization. Patients may be encouraged to use wellness centers and gyms as part of the plan to improve physical conditioning, diet, and stress management. In outpatient settings, the patient may be willing to keep a diary of symptoms, events, and diet that can be reviewed by the outpatient provider.

Substance use disorders commonly occur in all patient populations, but are commonly missed in comprehensive medical assessments. The PCM should be sensitive to the harmful and potentially addictive use of alcohol, medication, and illicit drugs that transcend all three areas. Treatment programs that comprehensively address addiction recovery have high success rates and should be expected to significantly improve the patient's quality of life and functional level.

## L. Initiate/Continue Treatment

### Annotation

CFS/FM has significant negative impact on the patient's physical, mental and social well-being. Multidisciplinary treatment should cover these three main

areas. Interventions expected to improve physical well-being include a graduated exercise regimen (monitored through physical therapy, exercise trainers, and social supports), improved sleep habits, and medication (monitored by the physician). Mental well-being may be improved through individual or group therapy, medication, and creating a supportive social network. Social well-being may be improved through resolving legal, financial, occupational, or recreational problems.

The expected outcome of intervention should be to significantly alter the patient's lifestyle and improve the identified problem areas, rather than discover a disease etiology or "cure."

### Therapy Interventions

- With early recognition, patient education, and effective multi-modal management, most patients with CFS/FM condition can lead a fairly normal life.
- The optimal intervention for FM would include non-pharmacologic treatments, specifically graded aerobic exercise, and cognitive-behavioral therapy, in addition to appropriate medication management, as needed for sleep and pain symptoms.
- The optimal interventions for CFS would include non-pharmacologic treatments, cognitive-behavioral therapy and moderate aerobic exercise, in addition to appropriate medication management as needed for associated depression, insomnia or myalgia, and sleep hygiene.

The following summarizes the therapies for CFS and FM and the potential benefit or harm of these interventions based on evidence from randomized controlled trials. The significance of the results of the research is indicated using the "Recommendation" (R) grading system described at the end of the Major Recommendations and in Appendix 1 of the original guideline document (e.g., R = A indicates significant benefits that are based on good clinical trials). For detailed recommendations on the treatment interventions, see Section B: "Therapy Interventions for CFS/FM" in the original guideline document.

### Therapy Interventions for FM

#### Some Benefit

- Cognitive behavioral therapy (Recommendation grade A)
- Graded aerobic exercise (A)
- Antidepressant – Tricyclic antidepressant (TCA) (A)
- Tramadol (B)
- S-adenosyl-L-methionine (SAME) (B)
- Selective serotonin reuptake inhibitor (SSRI) (B/C)
- Nonsteroidal anti-inflammatory drugs (NSAIDs) (B/C)
- Sleep education (C)
- Other antidepressants – non-SSRI, non-TCA (C)

#### Possible Benefit

- Acupuncture (B)
- Biofeedback (B)
- Trigger point injection (B)
- Stretching (B)
- Massage therapy (C)
- Relaxation therapy (C)
- Myofascial release (C)
- Spinal manipulation (C)
- Hypnotherapy (C)
- Magnesium (C)

#### Possibly Harmful

- Xanax (B)
- Antiviral (C)
- Antifungal (C)
- Antibiotics (C)
- Bed rest (D)

#### Therapy Interventions for CFS

##### Maximum Benefit

- Cognitive behavioral therapy (A)
- Graded aerobic exercise (A)

##### Some Benefit

- Monoamine oxidase inhibitors – (MAOIs) (B)
- Nicotinamide adenine dinucleotide – (NADH) (B)
- Sleep education (C)
- SSRI (C)
- Other antidepressants – non-SSRI, non-TCA (C)

##### Possible Benefit

- Relaxation (C)
- Flexibility exercise (C)
- Essential fatty acids (C)
- Magnesium (C)
- Low-dose, short term corticosteroid (B/C)

##### Possibly Harmful

- Florinef, alone (C)
- Bed rest (D)
- Corticosteroid – High-dose or replacement (D)
- Antiviral (D)
- Antifungal (D)
- Immune therapy (D)

## Sleep Hygiene

In patients with CFS, behavioral approaches to sleep-wake cycle disturbances are likely to be more successful than pharmacologic approaches, as the latter do not induce normal sleep. Cognitive and educational management approaches should be aimed at promoting an understanding of the role of disordered sleep, and dispelling any irrational fears or inappropriate beliefs about sleep. Relaxation training and stress management may be useful for some patients.

The aim of sleep management is to establish a regular, normalized sleep-wake pattern. Patients should be encouraged to:

- Restrict the night-time sleep period to about eight hours.
- Avoid going to bed too early in the evening.
- Avoid stimulants during the evening period.
- Wake at a regular time in the morning (e.g., 7 am).
- Arise from bed at a regular time in the morning (e.g., by 8 am).
- Reduce (to less than 30 minutes) or abolish daytime naps.
- Engage in daytime physical and mental activities (within the limits of the individual's functional capacity).

If a patient with CFS has a concurrent primary sleep disorder (e.g., sleep apnea, restless leg syndrome, or narcolepsy) specific intervention is required. The goals of sleep management should be to establish a regular, unbroken, night-time sleep pattern and to improve perceptions of the quality of sleep.

## Brief Introduction to Cognitive Behavioral Therapy (CBT)

CBT has been found to be particularly beneficial for patients with CFS/FM. If CBT is not available to your patients or they are not interested in seeing a mental health provider, the clinician may wish to consider utilizing some aspects of CBT in their clinic-based management. The following measures may help to empower patients and prevent them from dwelling on their symptoms:

- Work with patients to find more effective coping mechanisms.
- Help patients understand how avoiding activity and staying in bed may exacerbate their symptoms, rather than improving them.
- Encourage patients to maintain diaries, initially recording such items as weight, diet, sleep, and other objective elements.
- Later, guide patients toward writing more about life events and feelings and emotions; help them to see connections between life events and emotions, and in turn, physical symptoms.
- Help patients understand how expressing their feelings, either verbally or in writing, may help to prevent manifestation as somatic symptoms.
- For creative or artistic patients, encourage creative writing, which has been shown to improve the health status of patients with asthma and rheumatoid arthritis (Smyth et al, 1999), or artwork.

## Patient and Family Education

Some patients want only to be told that their condition is non-progressive and not causing damage or inflammation to their body. These patients generally have milder symptoms that have been present for some time and possess adequate strategies for improving symptoms and maintaining function. Education may be the only necessary treatment for these patients.

Patient education is of paramount importance for ALL patients with CFS/FM. The clinician should describe the condition in terms comfortable to them, and then refer the patient to reputable sources for additional information. Several national patient support organizations (e.g., American Fibromyalgia Syndrome of America, National Fibromyalgia Research Association, and Fibromyalgia Alliance of America) produce excellent materials to help patients with FM learn more about their illness. Patients should be warned about getting information from less reputable sources, particularly on the Internet, where there is a great deal of misinformation.

Internet-savvy patients may be interested in learning more from web sites. Patients should be warned about the lack of evidence for, and potential harm from, some suggested "cures" that may be espoused by Web sites or other sources (e.g., Internet Chat/Support Groups). The high rate of placebo responses in conditions such as CFS/FM allows some poorly controlled studies to indicate benefits when there are no true benefits and possibly harmful effects.

Helping patients to gain a clear understanding of the nature of their illness is an important element of care management. For example, some patients harbor fears that an infection or environmental pollutants may be causing irreversible damage. Others may have been led to believe that any physical activity at all could be harmful. Unwarranted concerns of this kind may lead to maladaptive attitudes and behaviors that may increase the disability and retard recovery.

### Psychosocial Support

As with other chronic illnesses, managing patients with CFS/FM requires consideration of the psychological and social impacts of the illness. Patients may be unable to continue full-time work, so financial difficulties may rapidly develop.

A successful return to work or school after a prolonged illness with CFS/FM often requires a rehabilitation program that incorporates medical treatments, psychological support, and occupational therapy. The clinician may need to coordinate the help of other health care and educational professionals to implement the appropriate program for the patient.

Consideration should also be given to the impact that the illness may be having on the patient's family. In some circumstances, it may be useful for the spouse or partner to accompany the patient with CFS/FM to a consultation, to help them better understand the illness and provide an opportunity to discuss any coping difficulties.

Joining a patient support group may be valuable for some patients. Support groups can offer individual and group support, education, and advice (e.g., how to gain access to social welfare agencies). Patients may also benefit from the opportunity to exchange coping strategies for dealing with day-to-day difficulties common to those living with debilitating conditions. However, the quality of advice can vary and it is therefore useful for the clinician to be knowledgeable about the activities and attitudes of local support groups.

With early recognition, patient education, and effective multi-modal management, most patients with CFS/FM can lead a fairly normal life. Clinicians should be prepared to act as advocates for their patients in negotiations with employers, educational institutions, and social welfare organizations. For instance, the patient may need assistance in arranging part-time work or school alternatives or securing disability allowances.

The clinician should refocus the attention from symptoms to improving patient functioning. Potentially modifiable psychosocial barriers to patient functioning could include the following:

- Living environment—Homelessness can perpetuate chronic illness as the result of environmental exposure and virtually non-existent personal hygiene.
- Support systems—Negative support on the part of the spouse, family, or significant other can impair and even worsen functionality.
- Job—Work place factors have been associated with illness-related behavior.
- Finances—Disability compensation can perpetuate illness by requiring continuing symptoms and disability for the worker to be eligible for benefits.

#### M. Follow-Up with Scheduled Visits, Usually at Frequent Intervals

##### Objective

Promote adherence to therapy and monitoring of clinical status.

##### Annotation

- The goal of follow-up visits is to monitor the severity of symptoms, impact of the symptoms on activities, effects of treatments, and presence of adverse effects to treatments, and assess patients for new symptoms suggestive of other diagnoses.
- Scheduled visits are preferred over as-needed (PRN) revisits.
- The amount of time between visits will vary depending on a number of factors, including the following:
  - Quality of the provider/patient relationship (i.e., new or established patient)
  - Distress of the patient
  - Need for refinement of the treatment plan
  - Presence or absence of psychosocial stressors
- If symptoms remit, the interval between follow-up visits may gradually lengthen.
  - Initially, a revisit at two to three weeks would be appropriate.

- As soon as the patient is doing well, then revisits every 3 to 4 months would be recommended.
- Visits at one to two-month intervals may be needed for patients on a graded exercise program or weight loss program to reinforce compliance.
- Continually re-evaluate the patient for worsening of chronic symptoms or presence of new symptoms suggestive of other diagnoses.

#### N. Reassess Symptoms Severity

##### Objective

Track the patient's clinical response to treatment.

##### Annotation

The primary reason for assessing current symptom status is to compare to the baseline status and estimate the response to active treatment strategies. With the lack of objective findings, treatment response must be monitored using subjective patient reports of symptoms and their impact on functional status. Though the symptoms are subjective, it is possible, using standardized questioning, to obtain reproducible measurements of the patient's clinical status. The following standardized assessments are recommended:

For pain: "On a 0 to 10 scale, 0 being no pain and 10 being pain as bad as you can imagine, what number would you say your pain has been over the past week?"

For symptoms other than pain: "On a 0 to 10 scale, 0 being no (insert SYMPTOM) and 10 being (insert SYMPTOM) as bad as you can imagine, what number would you say your (insert SYMPTOM) has been over the past week?"

For symptom impact: "During the past week, how much have your symptoms interfered with your usual work or activities, 0 being does not interfere at all and 10 being completely interferes?"

The clinician should initiate a complete initial symptom assessment (e.g., symptom duration, onset, triggers, and severity for new symptoms not previously assessed) (see Annotation D).

#### O. Adjust Treatment; Encourage, Reinforce, and Monitor for Emerging Conditions

##### Objective

Provide appropriate, effective follow-up, reassurance, and patient education for patients with CFS/FM.

##### Annotation

With patient consent, the clinician should become less involved as the patient is able to sustain lifestyle changes that have positive impact on functional ability and quality of life.

- Assure the patient that you believe their symptoms are real.
- Assess progress towards negotiated goals.
- Reevaluate the patient, with special concern for new symptoms or worsening chronic symptoms.
- Respond to the patient's desire to change the treatment plan or behavior that indicates a need to re-evaluate the treatment plan.
- Assess the patient's adherence to treatment and address any barriers to treatment.
- Assist the patient to take an active role in their recovery.

P. Consider Consultation

Objective

Provide the clinician advice and guidance in treating CFS/FM.

Annotation

The primary care manager (PCM) is not expected to directly provide treatment, but is expected to serve as the focal point for a multidisciplinary approach to treatment that may span the continuum of care, beginning with self-management. The treatment team may include those from whom prior consults have been obtained, such as physical therapy, nutrition, social work, psychology, rheumatology, and significant others within the patient's social network. The primary care manager, with patient consent, may find it useful to involve the patient's employer/supervisor, spouse, and friends in the defined treatment team.

Mental health professionals should provide input into implementing psychotherapies and psychopharmacology in outpatient or partial hospitalization settings. Social workers should help build family and social support networks, or recommend changes in the patient's living situation, in order to create a positive support network. Within the most intensive treatment setting within the continuum of care, residential treatment may be required to assure the presence of a support network.

Q. Provide Symptomatic Treatment and Consider Consultation

Objective

Provide appropriate treatment and follow-up.

Annotation

For unexplained symptoms that are not CFS or FM:

- Continue time-contingent follow-up.
- Emphasize efforts to improve functioning.

- Monitor for treatable disease explanations for symptoms (including psychiatric disorders).
- Use rehabilitative psychosocial strategies (e.g., cognitive behavioral therapy [CBT], and gradual physical reactivation/exercise) and symptom-based pharmacologic therapies, as appropriate (see Annotation L).
- Reassess target symptoms and clinical status at each visit.

### Definitions:

#### Quality of Evidence

I Evidence is obtained from at least one properly randomized controlled trial (RCT).

II-1 Evidence is obtained from well-designed controlled trials without randomization.

II-2 Evidence is obtained from well-designed cohort or case-controlled analytical studies, preferably from more than one center or research group.

II-3 Evidence is obtained from multiple time series, with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.

III Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

#### Recommendation Rating

- A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated.
- A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered useful/effective.
- A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds.
- A recommendation, based on evidence or general agreement, that a given procedure or treatment may be considered not useful/effective.
- A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration.

#### CLINICAL ALGORITHM(S)

An algorithm is provided for [Medically Unexplained Symptoms: Chronic Pain and Fatigue](#).

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### REFERENCES SUPPORTING THE RECOMMENDATIONS

[References open in a new window](#)

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The annotations which accompany the algorithms in the original guideline document indicate whether the recommendation is based on expert opinion rather than scientific data. Where existing literature is ambiguous or conflicting, and where scientific data are lacking on an issue, recommendations are based on the expert panel's opinion and clinical experience.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Improve Patient Outcome By:

- Formulating an efficient and effective assessment of the patient's complaints
- Optimizing the use of therapy to control symptoms
- Minimizing preventable complications and morbidity
- Achieving satisfaction and positive attitudes regarding the management of chronic unexplained illness

### POTENTIAL HARMS

Adverse Effects of Antidepressants

- Sedative, anticholinergic, and cardiac toxicity side effects of amitriptyline
- Anticholinergic and central nervous system effects of cyclobenzaprine
- Sexual dysfunction side effects of fluoxetine
- Headache and sexual dysfunction side effects of venlafaxine

Adverse Effects of Analgesics and Other Drugs

- Nausea and dizziness side effects of tramadol
- Bleeding side effects of nonsteroidal anti-inflammatory drugs (NSAIDs)
- Allergic reactions to lidocaine injections
- Diarrhea and nausea side effects of magnesium

Risks Associated with Diagnosis

A diagnostic label may sometimes unnecessarily cause a patient to define him or herself as ill, an effect that could be especially problematic in occupational health care settings.

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

The guideline is not intended to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advances and patterns evolve. The guideline is based on information available at the date of publication, and is intended to provide a general guide to best practice. However, it should be emphasized that evidence-based clinical practice involves using of the best available research evidence, but also exercising of the practitioner's clinical judgment, to take into account individual patient preferences. The guideline can assist care providers, but the use of a clinical practice guideline (CPG) must always be considered as a recommendation, within the context of a provider's clinical judgment, in the care for an individual patient.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

## INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

### IOM CARE NEED

Getting Better  
Living with Illness

### IOM DOMAIN

Effectiveness  
Patient-centeredness

## IDENTIFYING INFORMATION AND AVAILABILITY

### BIBLIOGRAPHIC SOURCE(S)

Management of Medically Unexplained Symptoms: Chronic Pain and Fatigue Working Group. VHA/DoD clinical practice guideline for the management of medically unexplained symptoms: chronic pain and fatigue. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Jul. Various p. [148 references]

### ADAPTATION

Not applicable: The guideline was not adapted from another source.

## DATE RELEASED

2002 Aug

## GUIDELINE DEVELOPER(S)

Department of Defense - Federal Government Agency [U.S.]  
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United States Government

## GUIDELINE COMMITTEE

Medically Unexplained Symptoms: Chronic Pain and Fatigue Working Group

## COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Members of the Working Group: Mark Brown, PhD; Andre Barkhuizen, MD; Rick Bowlus, USA; Daniel J. Clauw, MD; Helen Cook, LTC, CFNP, USA; Tim Corcoran, Lt Col, USAF; Kathryn Dolter, RN, PhD, LTC, ANC, USA; Erin P. Edgar, MD; Cathy Ellis, PT; Charles C. Engel, Jr., MC, LTC, USA; Renata J.M. Engler, COL, MC, USA; Rosalie Fishman, RN, MSN, CPHQ; Nelson Gantz, MD; Jane L. Gilbert, MD; Clifton A. Hawkes, MC, USA; Ian Hickie, MD; Michael Hodgson; Stephen Humburg, Lt Col, USAF; Steven Hunt, MD; Sarah Ingersoll, RN, MS, MBA; Patricia Ingold, CPT, USA; Thomas Irvin, LTC, MC, USA; James Jones, MD; Howard M. Kipen, MD, MPH; John E. Kraemer, MHA; Kurt Kroenke, MD; Joanne Marko, MS, SLP; Gregory J. Martin, CDR, MC, USN; Fujio McPherson, LTC, NC, USA; Charles F. Miller, MD; Keith Morgan, LTC, NC, USA; Keary J. Mudie, LT, USA; Aron Primack, MD; George Pickett, MD; Gregory T. Rehe, Col, MC, USAF; Ralph Richardson, PhD; James R. Riddle, DVM, MPH, Lt Col, USAF, BSC; Michael Roy, LTC, MC, USA; Alice M. Savage, MD, PhD; Jim Schmitt, MD; Michael Sharpe, MD; Artie Shelton, MD; Robert Simms, MD; C. David Spencer, MD, PhD; Oded Susskind, MPH; Harry "Chip" Taylor, CDR, MC, USN; Dennis C. Turk, PhD; Debby Walder, RN, MSN; Joanne Ward, CANP; Christine D. Winslow

## FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

## GUIDELINE STATUS

This is the current release of the guideline.

## GUIDELINE AVAILABILITY

Electronic copies: Available from the [Department of Veterans Affairs Web site](#).

Print copies: Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q), 810 Vermont Ave. NW, Washington, DC 20420.

#### AVAILABILITY OF COMPANION DOCUMENTS

Various companion documents are available from the [Veterans Health Administration \(VHA\) Web site](#).

In addition, the [VHA Web site](#) provides references to related guidelines, performance measures, and other resources.

Also available:

- Guideline for Guidelines. Draft. Washington (DC): Veterans Health Administration, Department of Veterans Affairs. Available at: [VHA Web site](#).

#### PATIENT RESOURCES

None available

#### NGC STATUS

This NGC summary was completed by ECRI on February 12, 2003. The information was verified by the guideline developer on February 25, 2003.

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